24th September.—Reflexis lost entirely; occasional spasm. No paralysis. Heart sounds faint; no murmur; lungs clear; no cough; no rales; no rash or retraction of head ever seen.

Temperature was 108·6° on 22nd and 23rd, ice externally, iced drinks, iced enemata were all tried.

Patient gradually got weaker and thinner, subsultus tendinum present. Latterly he had a mixture containing Digitalis, Spt. etheri, Spt. amm. aromat. Blood was taken from a vein and sent to Kasauli for examination for micro-organisms. None were discovered.

No lumbar puncture was made.

Whatever the cause of this hyperpyrexia may have been, I think it shows that blood should invariably be examined at once for parasites.

A prognosis in a case of fever when parasites are not found may be very bad and should be guarded. It is most unfortunate that *post-mortem* examinations cannot be performed.

I am inclined to think that this may be a case of enteric with hyperpyrexia; parasites were found. Quinine was not given on 14th or 15th; subsequently given without producing any beneficial result.

EXTRA-PERITONEAL WOUND OF LARGE INTESTINE.

By P. St. C. MORE,
MAJOR, I.M.S.

An interesting example of the above rare lesion is, I think, worthy of record.

On the morning of the 29th March 1907, Mehar Din, a Dhobi, aged 30, was brought to hospital, suffering from a clean cut penetrating wound of left hypochondria, situated in the ninth intercostal space, mid axillary line; the injury was caused by a long knife in a friendly dispute with his brother.

On admission patient was in state of collapse, pulse quick and bounding; there was little or no hæmorrhage externally.

Refusing all surgical interference, he was put to bed, adrenalin chloride hypodermically and normal saline solution ʒii per rectum. From this, he rallied almost immediately. The external wound was sewn up and aseptically dressed.

Diet.—Very small quantities of milk and water to sip.

30th March 1907.—Considerable retching, abdomen tender and slightly distended; pulse rapid and very weak, temperature 102°F. A troublesome cough has now supervened, and complains of slight pain over base of left lung. Nothing abnormal to be made out on examination.

31st March 1907.—Passed several times to-day large masses of blood clot; in state of general collapse, but rallied under injection of saline solution and Adrenaline Chloride.

2nd April 1907.—Patient much better, but has daily passed several large blood clots. External wound completely healed, and general condition much more satisfactory; the temperature remains at average of 101°F.

4th April 1907.—Abdomen normal and no pain on palpation, but cough still troublesome, and temperature remaining high.

8th April 1907.—Motions normal and temperature fell this morning to normal.

12th April 1907.—Improving rapidly, and with exception of slight rise of temperature towards evening in normal health.

17th April 1907.—This morning was suddenly attacked with severe pain in bladder and shortly after passed a large quantity of blood per urethra. The bladder was washed out, several clots being removed. The bladder itself appearing normal. The temperature rose to 100° F.

18th April 1907.—Complains of severe pain over region of left kidney; blood still appearing in urine.

21st April 1907.—Urine now normal, and renal pain has quite disappeared; patient insists on leaving hospital, declaring that he feels perfectly well.

23rd April 1907.—Discharged at his own request.

Remarks.

The knife entered at level of costo-diaphragmatic reflexion of the pleura, perforating the costal attachment of the diaphragm, and must have passed below spleen and between that organ and stomach, entering the large intestine at or below the junction of splenic flexion with descending colon—at same time wounding the adjacent kidney. In this situation, the colon is *generally*, though not universally, without a mesentery: its posterior surface being bare and connected to diaphragm and quadratus lumborum, on both of which it rests, by loose connective tissue.

The kidney also is in contact with descending colon, the latter curving round its outer margin.

I assume the injury was as above described, as granting that it was a fairly large wound of intestine (as instanced by the large amount of blood passed by rectum), it is hardly conceivable that such an injury could be intra-peritoneal without causing fatal peritonitis.

The later hæmorrhage from the bladder is more difficult to explain, my diagnosis being that it indicated a wound of kidney, the natural outlet *viâ* ureter being for a few days blocked by extra-peritoneal extravasation, the result of injury to bowel and kidney or both.

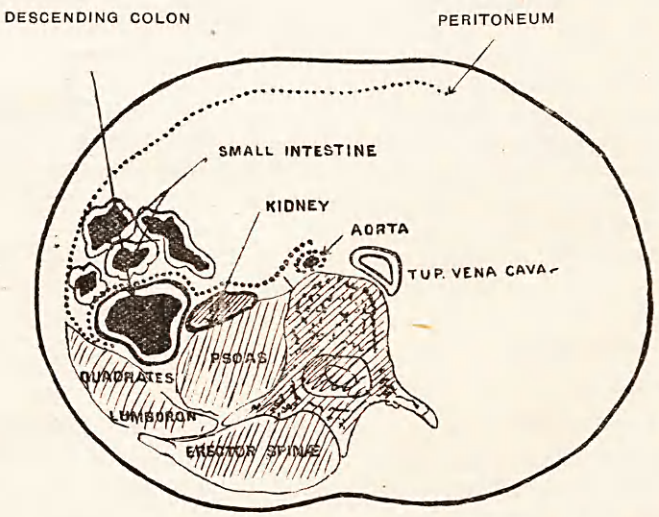
MULTIPLE ABSCESSES OF LIVER—RECOVERY.

(Written by Ramani Mohan Das,
Civil Hospital Assistant, Aijal Hospital, Lushai Hills District, Assam.
By F. G. HURST,
Civil Surgeon, Lushai.

Hira, aged about 24, Hindu, Gurkha male of the Lushai Hills Transport Corps, was admitted

EXTRA-PERITONEAL WOUND OF LARGE INTESTINE.

By Major P. St. C. MORE, I.M.S.



Rough Diagram of Transverse Section of Abdomen at level of injury, *i.e.*, lower border of 2nd L. Vertebra.